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ABSTRACT

This demonstration project provided specialized training to members of newly constituted healthcare ethics committees (HECs) across the United States. Between 1992 and 1996, 25 faculty with experience in healthcare ethics provided on-site training at hospitals and health centers in 54 communities in 32 states. Sixty training modules were developed and implemented during the project. The training programs were attended by more than 650 HEC members, representing medicine, nursing, social work, law, religion, and related professions. At most training sites significant numbers of non-HEC members attended one or more program sessions as well; an estimated 1,500 individuals participated in these programs. Local committee members helped design their programs. Half of the topical sessions were devoted to providing core information required to launch and run effective HECs. Other sessions covered basic ethical frameworks and principles drawn from the fields of bioethics, nursing ethics, or health law. In-depth coverage of bioethics issues associated with direct patient care were also covered in training sessions. Project evaluation results are presented, including participant characteristics and ratings of content and approach, organization and subject matter, instruction and relevance. Appendices include an evaluation form and biographical sketches of faculty members. (SW)

EDUCATING HEALTHCARE ETHICS COMMITTEES: THE EVALUATION RESULTS

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EDUCATING HEALTHCARE ETHICS COMMITTEES: THE EVALUATION RESULTS

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Project Overview

In 1992, the Fund for the Improvement of Postsecondary Education (FIPSE) awarded funds for an ambitious three-year project (P116B21587) which would provide specialized training to members of newly emerging healthcare ethics committees (HECs) across the country. As proposed, the project, based in the Center for Ethics, Medicine and Public Issues at Baylor College of Medicine, would bring nationally prominent university faculty with relevant expertise in the fields of bioethics, medicine and health law to those struggling with a growing number of ethical dilemmas on the front lines of healthcare delivery.

Ultimately, the project's Co-directors were successful in assembling more than two dozen faculty with healthcare ethics experience to assist in this effort. Between 1992 and 1996, the faculty offered one to three-day educational programs in 60 locations ranging from Maine to Florida to California. The sites included acute care hospitals, larger health systems, rehabilitation and chronic disease hospitals, university health centers and home care agencies. More than 650 HEC members representing the professions of medicine, nursing, social work, law, religion, and related professions attended these programs. At most sites, significant numbers of non-HEC members attended one or more program sessions as well. In all, it is estimated that approximately 1,500 individuals participated in these programs.

Evaluation data collected at the conclusion of each program shows that, despite varying training needs at the different sites and some logistical problems, even experienced HEC members valued this educational experience and believed that it would further their effectiveness in meeting their committee responsibilities. Often, they expressed a need and desire for continued training of the type provided under the FIPSE award.

Purpose

In their project proposal, Co-Project Directors Stuart Spicker and Judith Ross chronicled the emergence of a growing array of ethical dilemmas associated with the increasing technological sophistication and cost of healthcare in recent decades, and of the rise of healthcare ethics committees as tools for resolving ethical problems in individual cases and ethical healthcare policies at the institutional level.

They noted a number of milestones in the development of these committees including: (1) a growing concern with the provision and removal of life supporting respirators in the late 1970s, (2) the creation of the President's Commissions for the

Study of Ethical Problems in Medicine and Biomedical and Behavioral Research and publication of the Commission report Deciding to Forego Life-Sustaining Treatment in 1983, (3) the 1985 Department of Health and Human Services regulations encouraging the establishment of ethics committees within health care facilities to educate hospital personnel, (4) key Supreme Court decisions on the patient 's right to refuse treatment in the late 1980s, (5) passage of the Patient Self-Determination Act (PSDA) by Congress in 1990, and (6) a new Joint Commission on Accreditation of Healthcare Organizations requirement that hospitals have ethics committees or other vehicles for addressing ethical concerns (adopted in 1992).

By the early 1990s, these events had produced a well developed body of knowledge in the are of healthcare ethics, widespread introduction of HECs in hospitals and other healthcare organizations, and an emerging framework for HEC organization and functioning. Often, however, the knowledge, skills and perspectives essential to effective HEC functioning tended to emerge and remain in medical and law schools, university hospitals, and other academic settings. Despite rapid developments in the field, it appeared that most HECs were having to "find their own way" at this critical juncture in the development of healthcare ethics. The proposed project would address this central problem by bringing the required information to HEC members on their own ground; providing program participants with concrete strategies for running HECs as well as essential conceptual frameworks for ethical analysis. As noted above, evaluation data from the project repeatedly show that this effort, as proposed and carried out, was responsive to a deeply felt need on the part of many HECs across the country.

Background and Origin

In designing and carrying out the project, the Co-Project Directors were able to draw upon a previous effort towards establishing and addressing the educational needs of the new HECs. In the project, "Improving Hospital Ethics Committee: Educating Across the Health Professions," also funded by FIPSE (G008730468), Professors Spicker and Ross, and a multidisciplinary group of university faculty, devised and tested a model curriculum for educating the members of hospital ethics committees.

The week-long training program, was comprised of fourteen topical sessions providing in-depth coverage of procedural problems for HECs including the absence of consensus; theoretical and applied ethics; moral theories; medical, legal and ethical methods of analyzing ethical problems; matters of informed consent, privacy and confidentiality; advance directives and treatment options; death and brain death; professional integrity in patient care; and, ethical issues associated with the economics in patient care. Three additional sessions provided participants with opportunities to analyze cases, observe a working HEC, and give program faculty informal feedback.

This model program was offered at three different sites during the course of the project. The program was offered in California to fifteen new or recent HEC members, in Connecticut to fifteen HEC members with two to three years of committee experience, and in Florida to fifteen experienced HEC members with four or more years on such committees. In each instance, participants were drawn from local HECs and those in surrounding states. A pretest-posttest evaluation design showed that all three programs were well received by participants and found that new HEC members evidenced meaningful and statistically significant improvements in their knowledge of HEC organization and functioning, case analysis skills, and ability to access relevant bioethics literature.

While participants in this early project felt that few HEC members could devote a whole week to the intensive training which they had received, most believed that shorter "on-site" training programs would be highly valued by HECs in hospitals and other health care organizations across the country. The documented success of the initial programs and this informal feedback were major stimuli for proposing a demonstration project which would take HEC training to committees throughout the United States.

Project Description

Goals and Objectives

The goals of the new demonstration project were to: (1) disseminate the innovative health care ethics committee (HEC) curriculum constructed with previous FIPSE support; and (2) provide additional curricula needed by HECs to meet their self-educational responsibilities. A third goal, the creation of a permanent national center for HEC training activities in year three of the project was postponed in order to devote maximum project resources to achieving objectives associated with the first two goals.

Project goals were to be accomplished by recruiting and training additional project faculty, reorganizing the ethics curriculum into shorter training modules, and implementing a model of jointly-funded on-site training programs for HEC members. Specific objectives include: (1) recruiting and training thirteen additional program faculty members (bringing the total complement to 20); (2) conducting 20 on-site training modules per year for three years; and (3) organizing additional ethics education activities at local sites where appropriate. A national conference planned for year three to further the creation of a national center was set aside when that goal was postponed.

Key Activities

With the advent of the project in the Fall of 1992, the project Co-investigators

sought the participation of nationally recognized university faculty in the field of healthcare ethics to serve as field instructors for the planned on-site training programs. Those agreeing to participate in the project were added to its permanent faculty roster. Guidelines were established for the design of local programs, making faculty assignments, and faculty remuneration. In November of the same year, the Co-investigators, other project faculty, and the project's evaluator met in Chicago to discuss these guidelines, review and modify the ethics committee training curriculum created in the earlier project, and go over proposed evaluation procedures.

During this same time (and, subsequently, throughout the project), the FIPSE award and the nature of the program were publicized in the bioethics and healthcare communities through advertisements in relevant professional journals, announcements at national meetings, and mailings to hospitals throughout the country. By January, 1993, a brochure describing the project, its goals, and its faculty was being distributed nationally and expressions of interest were being received from a number of healthcare organizations.

In each instance of interest, the Co-investigators sought to determine the general and special training needs of the local HEC and establish tentative training dates. Committee personnel were then placed in contact with two or more project faculty who matched those needs by virtue of their academic specializations and availability. The faculty then worked with the local committee members to design a program covering core healthcare ethics curriculum as well as the committee's special interests and concerns. Programs were typically multidisciplinary in orientation with visiting faculty representing two to three disciplines. Once the program content and dates were set, the local committee became responsible for advance publicity and any necessary local arrangements. All programs were jointly funded, with faculty honoraria paid through the grant and travel expenses covered by the sponsoring hospitals.

Training under the project formally commenced on April 7, 1993 with a three-day program at the University of Florida Health Sciences Center in Jacksonville. The project's concluding training program was conducted on March 10-12, 1996, at Rancocas Hospital in Willingboro, New Jersey.

Evaluation/Project Results

Evaluation Procedures

Focus

Given the highly favorable evaluation of the earlier project's impact on participant knowledge and skills, and the limited resources available for evaluation of the new project, evaluation of the new activities focused on establishing the degree to which project staff were successful in expanding the

educational model and carrying it to a wider audience, rather than on determining the precise impact of the project on individual participants and committees.

With this focus, three broad evaluation questions were framed for the project: (1) Were project staff able to assemble the resources necessary to implement the proposed program? (2) Were, and how well were, the proposed training and service activities being carried out? And, (3) How well did these activities meet the educational needs of HECs, their members, and the organizations they serve?

Methods

Evaluation data addressing these questions were gathered by means of post-training evaluation forms. The forms provided participants with an opportunity to rate various aspects of the program 's content and approach, its organization, the value of individual sessions, the quality of instruction, and the utility of the program in meeting their HEC and other professional responsibilities. In addition, the form gave participants ample opportunity to make written comments in each of these areas, to note the most and least valuable aspects of the program, and to offer suggestions for improvement in the future. A background section requested information on the each participant 's profession, education, HEC experience, and exposure to previous ethics committee training.

The evaluation forms for each site were tailored to the local program, incorporating the name of the sponsoring organization, program dates, individual session topics, and program faculty. The required number of forms were forwarded to the HEC Chairperson in advance of the program, along with an explanatory letter and brief instructions for carrying out the evaluation.

The instructions requested HEC Chairpersons to administer the forms at a special evaluation session to be conducted at the end of the program. Committee members were to complete the forms anonymously, but to return them to the Chairperson in sealed envelopes with their names written on the outside. Chairpersons were asked to forward the sealed envelopes to the Project Evaluator in a preaddressed priority mail envelope together with copies of the HEC 's roster and program session attendance sheets (so that the extent of participation by committee members at each site could be determined). A copy of the evaluation instructions and a sample evaluation form care provided in Appendix E.

While Chairpersons were asked to limit evaluation to HEC members, forms from noncommittee members were often received as well. These forms were retained for future review, but were not used in formal evaluation of the project.

Information Received

A total of 646 evaluation forms were completed and returned by HEC members attending one or more program sessions. At least some evaluations were received from all programs, with the number of returns ranging from two to twenty-seven per session. Fifty of the sites (83%) submitted seven or more forms, twelve (20%) submitted twelve of more, and 5 (8%) submitted twenty or more forms. The average number of evaluation forms submitted per site was 10.7.

While all sites supplied at least some evaluation forms, adherence to the requests for other types of program information was often variable. Completed evaluation forms were sometimes supplied in anonymous batches rather then in individually signed and sealed envelopes as requested. In some instances, the requested committee rosters, session attendance information, or both were missing. In other cases, the HEC Chairpersons summarized attendance patterns rather than supplying the raw data. These deviations from the established evaluation procedures often made it difficult to establish precisely the number and proportion of HEC members attending the local programs and the number and proportion of attendees that participated in the evaluation process.

Enough data was received, however, to establish minimum attendance rates, based on attendance at one or more program sessions, for forty-three of the sixty sites. These rates show 90% or more of the committee members attending the program at twelve sites, 80-89% at four sites, 70-79% at eight sites, 60-69% at four sites, 50-59% at nine sites, 40-49% at three sites, and 30-39% at three sites. Because these rates are often based only on the number of forms received from HEC members rather than attendance sheets, it is likely the actual attendance by committee members was significantly greater at most sites. When they could be determined, evaluation form return rates among those attending sessions at the forty-three sites typically ranged from 60-90%.

Analysis

Upon receipt, the evaluation forms and associated data were reviewed for completeness. Attendance and evaluation rates were calculated as thoroughly as the data allowed. These rates and other key information about the programs, including their dates, the content of individual program sessions, and the participating project faculty were entered into a log for future reference and analysis.

The ratings from each program were then numerically coded, entered into a project database, inspected for accuracy, edited where necessary, and tabulated using the EpiInfo statistical analysis program. The resulting rating distributions

were entered into a facsimile of the site's evaluation form. Written comments from each site were subsequently typed and added to the facsimile. Finally, a cover sheet containing a brief description of the program and a narrative summary of the quantitative and qualitative evaluation results was prepared. These individual evaluation reports were forwarded to the project's Co-investigators in groups of six to twelve reports. The Co-investigators, in turn, provided project faculty with individual feedback stemming from the evaluation process.

Following completion of the final site report, summary evaluation ratings were tabulated for the entire 646 of the individuals submitting project evaluation forms. At the same time, the sixty individual evaluation reports, information logs, and other project documents were reviewed for recurring evidence of special project strengths, implementation problems, and important lessons learned from this unique project.

Findings

Faculty

By the November, 1992, meeting in Chicago, the project had identified the desired complement of twenty project faculty members. During the course of the project, a few of these individuals were lost to the project and several more added, bringing the total number of university faculty participating in the project to 25. All of these individuals held advanced degrees, all had trained in one or more disciplines pertinent to healthcare ethics, and all were located in or affiliated with university settings. Just over half (56%) of the faculty had trained primarily in bioethics and the humanities (one with an M.D. and one with a J.D. in addition to their Ph.D. degrees, four (16%) primarily in health law (one with an M.D. as well as a J.D.), four (16%) primarily in medicine (one with a J.D. as well as M.D.), and two (8%) primarily in nursing. The Project Evaluator, trained in the social sciences, was also identified as a member of the project faculty.

Programs

The sixty programs designed to educate the members of Healthcare Ethics Committees were conducted at hospitals and health centers in 54 communities. Programs were offered at two sites in Los Angeles and in Aurora, Colorado. Three programs were carried out in Fresno, CA, two by one hospital and the third by second hospital. In all, the project reached 32 states ranging from California to Maine to Florida. Twelve of the 60 programs (20%) were conducted in Northeastern U.S., 8 (13%) in the South, 15 (25%) in the Midwest, 8 (13%) in the Southwest, and 15 (25%) in Western states. The two remaining programs (3%) were conducted in communities in Puerto Rico. While most of

the states had only one or two programs, there were several programs in some states. Nine of the sixty programs were conducted in California, five in Michigan, four in Texas, and three in Missouri, and three in Connecticut. Forty-seven of the programs (78%) were carried out over two days. The remaining thirteen programs (22%) spanned three days. Most of the programs (70%) used two project faculty members; a quarter (27%) used three faculty members; and two programs (3%) used four faculty members.

Participants

Because nearly one-third of the sites failed to supply the requested committee rosters or session attendance sheets, and because many HEC members were reluctant to sign their sealed evaluation envelopes, the number and proportion of HEC members attending one or more program sessions can only be estimated. Based on participation and evaluation rates at sites where the requested information was supplied, it seems likely that only two-thirds of the HEC members attending the programs participated in the evaluation process. This would bring the total number of HEC members reached by the project up to approximately 1,000 individuals. Similarly, the comparison of attendance sheets with committee rosters, where present, showed that non-HEC members frequently attended regular or "plenary" program sessions, often accounting one-third to two-thirds of those attending one or more sessions. Based on these observations, it is likely that the project ultimately reached at least an equal number of non-HEC healthcare personnel.

Most of the HEC members who evaluated their FIPSE-sponsored training (39%) were nurses. About one-quarter (23%) were physicians. Social workers constituted nearly one in ten of those submitting evaluations (9%), as did clergy (8%) and administrators (8%). Educators accounted for 3%, and lawyers for 2%, of those completing the forms. The remaining 7% was comprised of other health professionals and community representatives.

One-third (34%) of these individuals held medical, law or other doctoral degrees. Another third (32%) were trained at the masters level. About a fifth (21%) held bachelors degrees. The remainder (13%) had associates degrees or high school diplomas.

More than a third (39%) were new HEC members with one year of committee experience or less. Almost one-third were moderately experienced HEC members with either two years (18%) or three years (12%) of committee experience. The remaining individuals were more experienced HEC members whose committee tenure ranged from four years (8%) to as much as ten or more years (6%). Two out of five (40%) of those submitting evaluation forms reported that they had received some type of formal ethics committee training prior to their participation in the FIPSE-sponsored program.

Content and Approach

All participants were asked to rate seven aspects of their program's general content and educational approach. With the exception of matters related to reading assignments and preparation time, most did so. The resulting ratings, presented as percent distributions in Appendix E and graphically in Figure 1, show that most HEC members were positive about the content and approaches employed by the project faculty. In all, three-quarters or more of those completing evaluation forms judged their program to be "About Right" in terms of the "Breadth of Material" (93%), "Depth of Coverage" (91%), "Speed of Presentation" (90%), "Time Spent on Lectures (86%), and "Time Spent on discussion" (77%). Because many of the sixty programs did not assign readings, either in advance or during the program, only about half of those completing evaluations rated their program on the remaining two criteria in this section of the form. Of those answering these questions, however, at least three-quarters felt that their program was "About Right" in the "Amount of Assigned Reading" (75%) and the "Amount of Preparation Time" given (83%).

While "highly favorable overall, these ratings and accompanying comments do show that at least some difficulties were experienced in meeting the participants' expectations and/or preferences regarding the use of lectures, discussion and assigned readings.

As many as one-forth of those reporting felt that their program faculty had failed to achieve a proper balance between lecture and discussion. Those with such concerns overwhelmingly would have preferred more opportunities for discussion, either in addition to, or as a substitute for, lectures. While only one in twenty (5%) felt that there had been too little lecture, about one in ten (9%) felt that there had been too much time devoted to lectures, and fully a fifth (20%) said that too little time had been devoted to discussion. In contrast, very few participants (3%) felt that too much time had been spent in discussion.

The desire for more discussion was also a recurrent theme in the participants written comments. Participants frequently identified the opportunity to discuss issues and concepts with the visiting faculty and with each other as among the "most beneficial" aspects of their training. Discussion was often identified as the most effective way of exploring the practical implications and applications of ethical frameworks presented under the lecture format; the primary concern of most participants. This was especially true when discussion afforded the opportunity to participate in analyzing real or hypothetical cases. While most participants did not discount the value of the lectures they received, their comments regularly attached special importance to the "openness," "spontaneity," and "interactive nature" of the discussions which they had participated; noting that opportunities for collective learning and discussion were rare in their busy work environment.

While achieving the desired balance between lecture and discussion was a continuing problem throughout the project, experience and feedback did bring about some improvement. Of the twenty programs conducted first year of the project, there were four in which 40% or more of those submitting evaluations said that there had been too little discussion. By the third year of the project, only two of twenty programs showed comparable levels of participant concern about limited discussion.

The matter of assigned readings appeared to be considerably less problematic. In general, most participants did not seem to expect assigned readings or miss them when not used. However, both ratings and comments suggest that the failure to make effective use of assigned readings may have represented a missed opportunity at many sites. When used, assigned readings often prompted positive comments about their value, with participants feeling that there had been too little (17%) rather than too much (8%) assigned reading. This was particularly true when readings were distributed in advance of the program. Distributing readings at the programs, even for purposes of follow-up reading, was more likely to prompt critical than positive comments from participants. Many indicated that, if the readings were really important, participants should have had an opportunity to go over them before coming to the program.

Organization

Participants were also asked to provide ratings on a seven dimensions of program organization. As shown in Figure 2 and Appendix F, at least 80% of those submitting evaluations judged the quality of the program to be "High" or "Very High" in six of the seven areas, including "Clarity of Objectives" (80%), "Selection of Topics" (92%), "Sequencing of Topics" (82%), "Value of Lectures" (90%), "Value of Discussions" (90%), and "Appropriateness of Reading" (83%). The "Value of Handouts" was judged to be somewhat lower, with a quarter of those reporting assigning them either "Fair" (22%) or "Low" (3%) ratings.

These highly favorable ratings suggest that the programs were well organized and executed at most sites. Logistical difficulties, while in evidence, appear to have been limited in both their nature and extent, centering around the communication of program objectives (by the sponsoring organization, the project faculty, or both), the sequencing of topics, and provision of effective handouts and readings. Even in these four areas, participant concerns were likely to be expressed in terms of "Fair" rather than "Low" or "Very Low" ratings.

Individual comments reinforce the picture of well organized programs. While problems with the quality of audio-visual materials, the adequacy of meeting

facilities, and the ability of presenters to stick to topics and timetables were sometimes noted, such concerns were rare. And, participants were just as likely to remark on how well their program had gone.

Session Topics and Ratings

From two to fourteen topic-oriented sessions were offered at each of the sixty site. As shown in Figure 3, about one in six programs (15%) offered two to four sessions, one in five (20%) had five or six sessions, about one in four (28%) seven or eight sessions, another quarter (27%) eight or nine sessions, and one in ten (10%) eleven to fourteen sessions.

Altogether, the sixty program generated 433 topic sessions. Since local committee members played key roles in the design of each program, the focus of the individual sessions provides a good indication of their concerns. The range of topics and number of sessions associated each topic is presented in Table 1. From the table, it can be seen that nearly half of the sessions were devoted to providing core information required to launch and run effective HECs. In all, 140 sessions (32%) addressed the history, roles and organization of HECs; taught case consultation methods; or reviewed local HEC cases. Another 71 sessions (16%), covered basic ethical frameworks and principles drawn from the fields of bioethics, nursing ethics or health law.

Another group of sessions provided in-depth coverage of bioethics issues associated with direct patient care. Of these, 54 sessions (12%) addressed fundamental patients' rights issues, 102 sessions (23%) dealt with issues involving end of life decision-making, and 17 sessions (4%) explored ethical issues arising in special treatment settings such as emergency rooms and critical care wards.

Finally, a growing concern with organizational ethics was evident over the course of the project, as more and more sites scheduled sessions on health care policy, creating an ethical organizational environment in healthcare settings, and the ethical dilemmas associated with the rise of managed care. In all, 56 sessions (13%) addressed such topics. The three remaining sessions offered participants forums for open discussion.

As part of the evaluation process, each program participant was asked to rate the sessions that they attended according to how useful the presented material would be in meeting their HEC responsibilities, In all, the participants offered 4,025 session ratings. The frequency distribution of these ratings is depicted in Figure 4. From the figure, it is evident that an overwhelming proportion of the program sessions were well received by most participants. More than a half (51%) were "High" ratings and more than one-quarter (28%) were "Very High" ratings. Most of the remaining session ratings fell in the "Fair" rather

than the "Low" range. In all, 17% of the session ratings were "Fair," and only 4% either "Low" (3%) or "Very Low" (1%).

The session rating distributions and written comments provide indications of why some sessions were less well received than others. Typically, "Fair" ratings were associated with highly specialized sessions. For example, many who attended sessions focusing on issues in pediatric, emergency room, or other specialized settings indicated that the presented material, while interesting, was simply not relevant to their every day experiences. At the same time, those who worked in such settings often said that they were already familiar with much of the material presented. This sometimes prompted even lower ratings.

More often, however, low session ratings were associated with overly ambitious program planning. In general, those programs scheduling ten or more sessions were more likely to receive "Low" or "Very Low" ratings for one or more program sessions. In such cases, participants often alluded to the complexity of the program, felt that "too much had been attempted, " and noted that there had been too little opportunity for active participation by those attending the program.

Instruction

While about one-fifth of the individual program sessions received ratings in the "Fair to Low" range, the evaluation results show that the HEC members rarely attributed the cause to shortcomings in the area of instruction. Instructional ratings were uniformly superior, and comments about instruction highly favorable, throughout the project. As shown in Figure 5, at least nine out of ten (92%) of the HEC members rated the program "Highly or "Very Highly" in terms of the "Overall Clarity of Instruction" (92%), "Scholarly Level of Instruction" (95%), "Instructor's Interest/Enthusiasm" (97%), "Readiness to Provide Assistance" (95%), Responsiveness to Questions/Concerns" (95%), and "Level of Rapport with Participants" (94%).

Among all of the program dimensions evaluated, instruction was the most likely to yield "Very High" ratings. With one exception (overall clarity of instruction), all aspects of instruction were rated "Very Highly" by more than half (54%-61%) of those reporting. In individual comments, participants attached great importance to the credentials of the visiting faculty members, their knowledge of ethical issues, and their willingness to share experiences gained by working with other HECs across the country. The chance to hear from such faculty and, especially, to interact directly with them was clearly seen as an exceptional opportunity.

Summary Ratings

The positive program ratings in the areas of the content and approach, organization, subject matter, and instruction are reflected in the participants ' summary ratings of their training experiences.

Nine out of ten completing evaluation forms rated their program either "Highly" (41%) or "Very Highly" (50%) in terms of "Intellectual Challenge." Four out of five gave it a "High" (49%) or "Very High" (30%) rating for "Exposure to New Material." The participants ' assessments of the usefulness of the FIPSE training were similarly favorable. More than half (53%) gave their program a "High" rating for its "Utility in Meeting Ethics Committee Responsibilities," while another third (35%) gave it a "Very High" ratings on this dimension. Significantly, the programs were seen to be almost as useful in carrying out non-HEC activities. When asked to assess the utility of their program "In Meeting Other Professional Responsibilities, " more than four out of five gave it a "High" (52%) or "Very High" (29%) rating.

Finally, participants were asked whether their program, as a whole, had lived up to its publicized description and to provide a single "overall" rating for the program. While many individuals responded that they had not seen any advance descriptions of program content, or simply failed to provide a response, 525 (83%) of those completing the evaluation form did answer the question about whether or not the organization and content of the program matched its publicized description. Of those, fully 93% said that the program had fulfilled their expectations. Of 628 individuals providing overall program ratings, 48% assigned their program a "High" rating and 45% assigned it a "Very High" rating.

Summary and Conclusions

Project Strengths

The evaluation data from this project point to a number of programmatic strengths relating to the mission, conduct, and apparent impact of the project.

Addressing A Critical Need

First and foremost, this project identified and addressed a critical unmet educational need among those involved in the provision of contemporary health services. In their proposal, the Co-Project Directors argued that the growing body of knowledge required to effectively deal with an escalating number of health care ethical dilemmas was not reaching members of the newly formed Healthcare Ethics Committees charged with responding to such problems. From

the first program in 1993 to the end of the project, evaluation ratings and written comments showed that this was all too often the case.

In their written comments, program participants regularly observed that, as HEC members, they had been meeting with little understanding about their committee 's charge or how it should be met. Often, they openly expressed the view that they were ill equipped to handle the cases coming before their committees, that they often felt as though they were "operating in the dark," and that, in such circumstances, they had little recourse but to act on the basis of their own values, opinions and perceptions. Because of the critical nature of the issues brought before them, most, even experienced HEC members, felt uncomfortable with this approach.

For these reasons, participants attached extraordinary importance to the FIPSE training which they received. For many, the discovery that relevant ethical frameworks, concepts, analytic methods, and operating procedures existed was both a revelation and tremendously reassuring. Gaining awareness of such tools, practicing their use in their every day work setting under expert guidance, and leaning that other HECs were facing similar struggles were typically identified among the most beneficial aspects of their training. While most participants seemed to recognize that their formal ethics training was just beginning, they nonetheless communicated feelings of renewed confidence and relief that they no longer had to "go it alone."

Mobilization of Resources

The ability to mobilize critical resources was a second important strength of this project. Within a matter of months, the project 's Co-directors were able to secure the participation of twenty nationally prominent experts in healthcare ethics as project faculty. While nominal honoraria were provided for each site visit, such participation was clearly prompted by professional dedication to the further development of the field of healthcare ethics and the conviction that local HECs were in serious need of formal training. Since this project was carried out during a period of consolidation and tightening budgets in healthcare delivery, securing sixty organizational commitments for jointly funded training programs also represented a formidable achievement. Finally, the project was successful in drawing upon and appropriately adapting the earlier HEC curriculum to the demonstrations project 's new educational format.

Programmatic Flexibility

A third element in the success of this project was the ability to take ethics training into the field and, where necessary, to adapt the project 's basic educational strategy to the nature, needs and interests of the sponsoring

organization. The model of individually tailoring local programs around core sessions on HEC operations, sessions on "generic" bioethics concepts and issues, and additional sessions on topics of special concern at the local level served the project well. It accommodated the training needs of different types of healthcare settings such as hospitals, health maintenance organizations, and home healthcare agencies. It also accommodated the needs of local HECs with varying levels of experience.

This flexibility also allowed local committees and sponsoring organizations to effectively pursue multiple agendas through the training programs. As a result, programs were frequently used to further a variety of ends in addition to training HEC members. These included such objectives as enhancing the committee 's reputation within the organization, recruiting new committee members, sensitizing all employees to ethical concerns, and increasing organizational visibility in the wider community. Although the pursuit of multiple agendas through the training programs sometimes posed special problems, the opportunity to do so undoubtedly helped many sponsoring organizations to commit scarce resources to the project.

Multidisciplinary Perspective

As they have emerged on the healthcare scene, HECs are inherently multidisciplinary bodies, bringing practitioners from a variety of healthcare and related professions together to consider wide ranging ethical dilemmas.

While the commitment to a multidisciplinary approach in healthcare has grown in recent years, multidisciplinary efforts and initiatives have met with mixed success in the face of conflicting disciplinary perspectives and the traditional hierarchy of authority among the health professions. In the evaluation process, the HEC members who participated in this project frequently alluded, explicitly or implicitly, to the challenges of working through ethical problems with colleagues whose perspectives and responsibilities often differed radically from their own. For these individuals, the project 's multidisciplinary orientation was another important strength of the project. They saw the project 's multidisciplinary ethics curriculum, its multidisciplinary faculty, and the opportunity to train with colleagues from other disciplines as essential elements of a rewarding and productive training experience.

This was particularly evident in participants ' responses when questioned about the "most beneficial aspect of their training." "Hearing the different faculty perspectives," "exposure to ethical frameworks which we can all use," and "the opportunity to work through ethical problems with others in a non-threatening situation" were all identified as especially beneficial aspects of their training.

Practice Orientation

An explicit concern with the application as well as the substance of ethical frameworks represented a fifth important strength of this project. While most programs devoted considerable time to presenting alternative ethical and legal frameworks for identifying and analyzing ethical dilemmas in healthcare, much more time was devoted to methods of putting this new knowledge into practice. Sessions on specific healthcare ethics concepts, methods of case analysis, HEC operating procedures and setting health policy all gave participants the sense that they were receiving tools which they could readily put to good use. Ultimately, this led 80-90% of the participants to characterized the training they had received as highly useful in meeting their HEC and other professional responsibilities.

Technical Excellence

Like any ambitious, complex, and lengthy undertaking, the execution of this three-year project was by no means flawless. Several recurring problems, logistic in nature, were observed and are discussed below. Throughout the project, however, such problems were consistently overshadowed by an overwhelming sense of technical excellence. This technical excellence represented a sixth important strength of the project.

At the local level, sponsoring organizations and committees were clearly impressed with the relevance and national character of the project, the caliber of the faculty, and the overall quality of the programs that were conducted. Having been given an opportunity to participate in the selection of visiting faculty and the design of the local programs, the vast majority of participants approved of the scope and educational approach of the program they attended. Nearly all participants found their programs to be well organized and judged lectures, discussions, and educational materials to be of high or very high quality. While some program sessions were seen as less useful than others, most sessions were seen as valuable by most of those attending them. Instruction was routinely seen to be superior, even in sessions which were thought to be of less practical value.

This sense of technical excellence clearly reinforced the value of the educational experience in the minds of program participants. When asked about the "least beneficial aspect of their training," participants repeatedly replied "none," that "it was all beneficial," or that "everything was well done," rather than leave the question blank. When queried as to how the program might be improved, participants offered similar responses or suggested minor changes in areas such as scheduling or location. Coupled with the critically relevant focus and applied orientation of the project, this technical excellence in execution prompted 93% to assign their program high overall ratings.

Implementation Problems

In contrast to the many important strengths and overall success of this project, problems associated with its implementation were few and relatively minor in nature. Nonetheless, these difficulties did adversely affect some local programs, held a potential to compromise the project's overall success, and offer some lessons for future ethics training of healthcare personnel at the local level.

Multiple Agendas and Negotiation

As noted above, many of the local healthcare organizations sponsoring the ethics training programs did so with the hope of furthering multiple agendas. In most instances this goal did not substantially alter the nature of the on-site training program or compromise the attainment of project objectives. In isolated instances, however, the presence of conflicting objectives does appear to have had adverse affects relative to the goals of the projects and even of local committees. This was particularly true when multiple agendas were coupled with a natural desire to derive the maximum benefit from the organization's financial commitment to the program.

One especially common example of multiple programs agendas involved the desire to educate personnel throughout the sponsoring organization, as well as HEC members, about ethical issues. A third objective, meeting continuing education requirements for professional licenser and organizational accreditation, was often added to the mix. Typically, these goals were accomplished by scheduling an evening or noontime session on a more general topic and opening it up to all personnel. This approach accommodated the supplementary objectives while leaving the bulk of the program sessions for focused training of HEC members. At a number of sites, however, a larger proportion of session were identified as "open sessions." And, at a few sites, the training took on the character of a two-day institution-wide ethics conference with plenary sessions, breakout sessions, and open forums. Where this occurred, it clearly altered the nature of the training program, moving it away from a specialized, intensive, and intimately shared training experience for committee members.

Similarly, the desire to minimize program costs, to get the largest return on their investment, or both led some sponsoring organizations to try to share program expenses among members of a larger health system or to press for large numbers of sessions over a two day period. In general, these approaches appear to have been counter productive, making it difficult to address the needs of a single functioning HEC and resulting in longer and more complex programs that were generally less well received by participants.

Advance Preparation and Local Arrangements

Most programs appear to have been well organized, well executed and well attended. In general it appears that the project's Co-directors, project faculty, and local HEC chairpersons did a good job in designing and carrying out the local programs. At the same time, it is clear that at some sites, there was less than perfect follow through on this solid groundwork. Participants frequently observed that they had not received advance information about the program and/or that they had failed to receive advance readings sent to the local committees by project faculty. In other instances, concerns were expressed about the adequacy of audiovisual materials, meeting facilities, and presentation handouts. While such concerns, directed primarily to local planners and the sponsoring organization, were infrequent and relatively minor, they did mar the program for some participants and certainly represented missed opportunities for excellence. Finally, poor advance planning at the local level may have limited HEC member attendance at some sites. In written comments from several sites, participants "wished that there had been better attendance by HEC members, especially physicians."

Matching Educational Objectives and Formats

As noted above, project faculty at some sites experienced difficulty in achieving the balance between lecture and discussion desired by program participants. While the problem was a relatively minor one which diminished somewhat over time, it was nonetheless evident throughout the three-year project. At least in part, this continuing problem probably reflected a discrepancy in preferred learning styles between academically-based program faculty, who often consider lecture to be a desirable and efficient means of instruction, and the practice-oriented healthcare personnel who preferred a more participatory approach to learning. Although most faculty did seem to limit the amount of time devoted to lecture, they may still have underestimated the extent to which those in clinical practice appreciate a hands on approach to learning. In any future effort of this kind, the debates, simulations, case analyses, and discussion sessions which were so well received at all sites should probably receive even greater attention from project faculty.

Conclusions

Further analysis of the evaluation data from this project may shed additional light on particular training benefits or problems for HEC members of varying backgrounds. Such analysis might, for example, show that program participants from different disciplines or with different levels of HEC experience benefited from their training to different degrees and/or in different ways. Or, that they preferred

alternative educational formats. The initial tabulation and analysis of evaluation data, however, together with review of project documents and records, provide clear evidence that this ambitious project was successful in meeting its overall goals and objectives. Expert faculty were identified and recruited to the project, commitments of joint funding for local training programs were secured from sixty healthcare organizations across the country, and the vast majority of those attending the programs characterized their training experience as well organized, well taught, and highly relevant to meeting their HEC and other professional responsibilities. Given this level of success it is unfortunate that further strides towards institutionalizing this initiative in the form of a national academy could not be achieved.

Table 1. Session Topics for 443 Program Sessions

HEC Structure and Functioning	
HEC History, Roles, Organization	99
Case Consultation Methods	24
Review of Local HEC Cases	17
Ethical Frameworks and Principles	
Bioethics, Ethical Issues and Alternative Models	49
Nursing Ethics	11
Health Care Law	11
Organizational Ethics	
Hospital Policy and Environment	22
Ethics and Managed Care	34
Patient Rights	
Patients' Rights	22
Informed Consent	15
Patient Competence	13
Confidentiality	4
Special Ethical Problems	
Ethics of Emergency Room and Critical Care	4
Neonatal and Reproductive Care	32
Organ Transplant and Fetal Tissue	3
End of Life Decision-Making	
Advance Directives and DNR	32
Withholding and Withdrawing Treatment	22
Medical Futility	27
Artificial Nutrition & Hydration	3
Dying and Palliative Care	10
Assisted Suicide and Euthanasia	8
Other	
Open Discussion	3
TOTAL	433

Fig. 1 Content and Approach
(n=355-636)

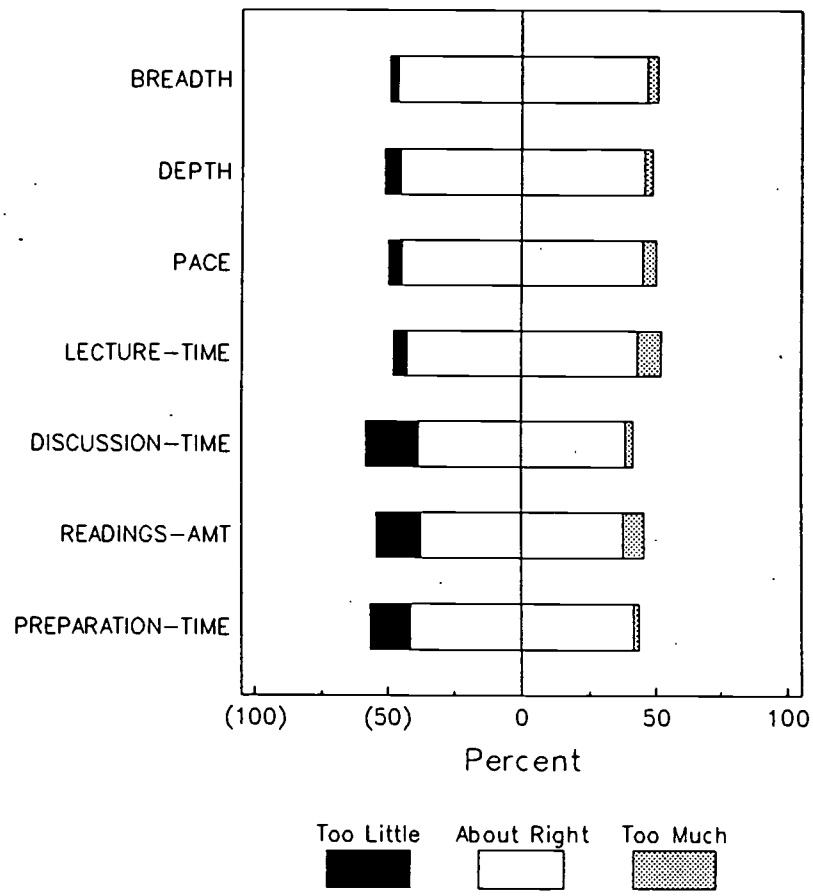


Fig. 2 Organization and Subject Matter
(n=385-635)

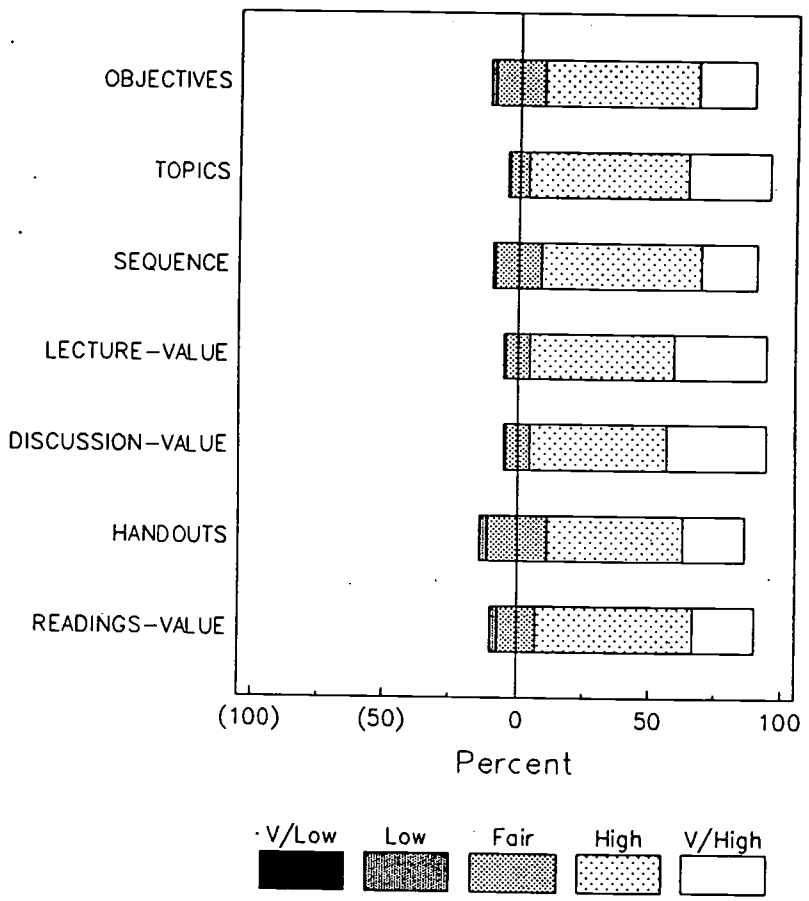


Fig. 3 Number of Program Sessions
(60 Programs)

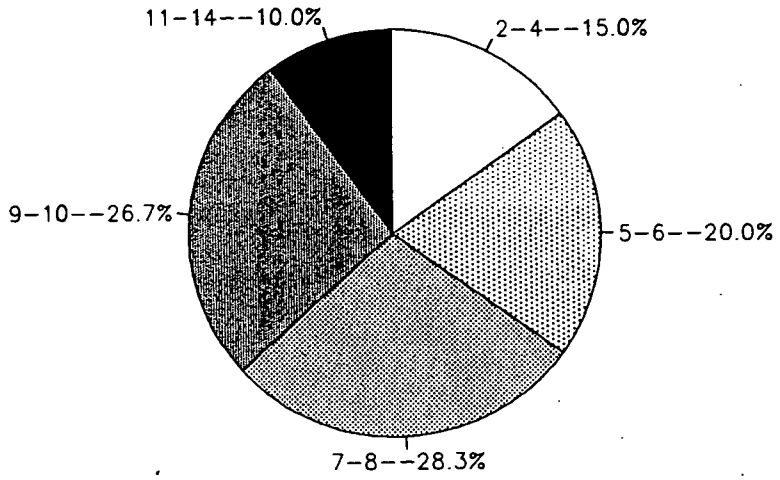


Fig 4. Session Ratings
(4,025 ratings)

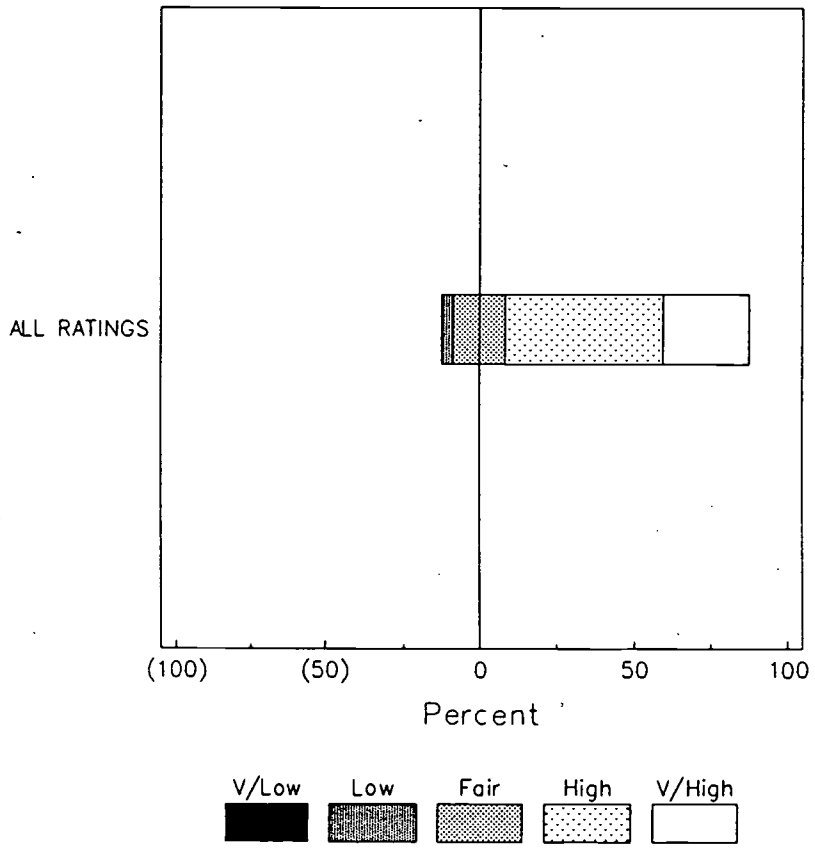


Fig. 5 Instruction
(n=626-635)

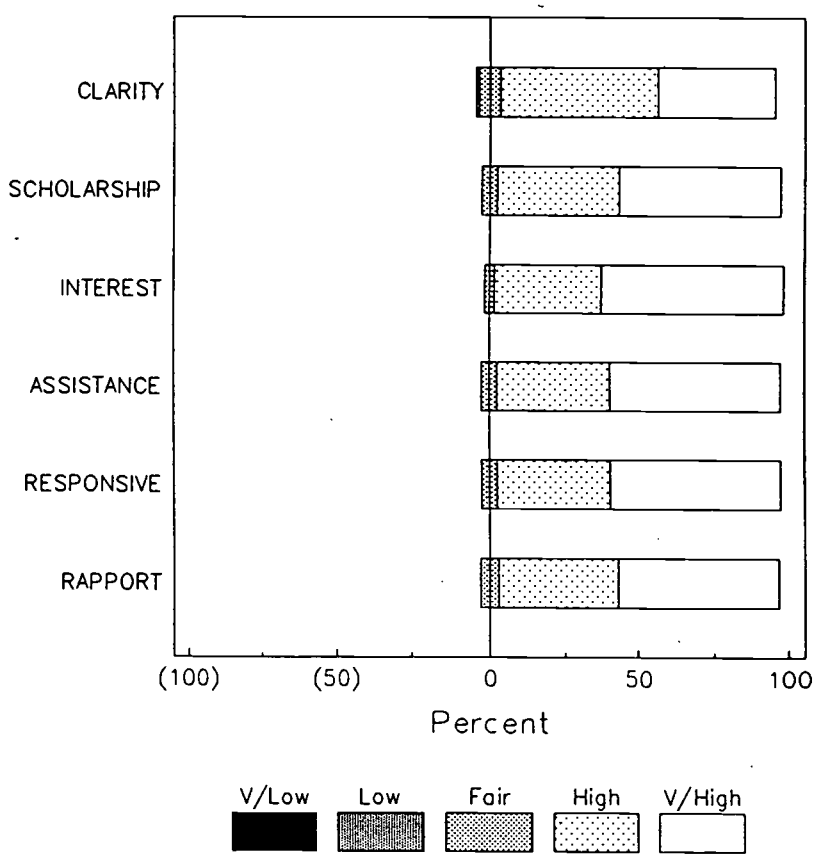


Fig. 6 Relevance
(n=607-637)

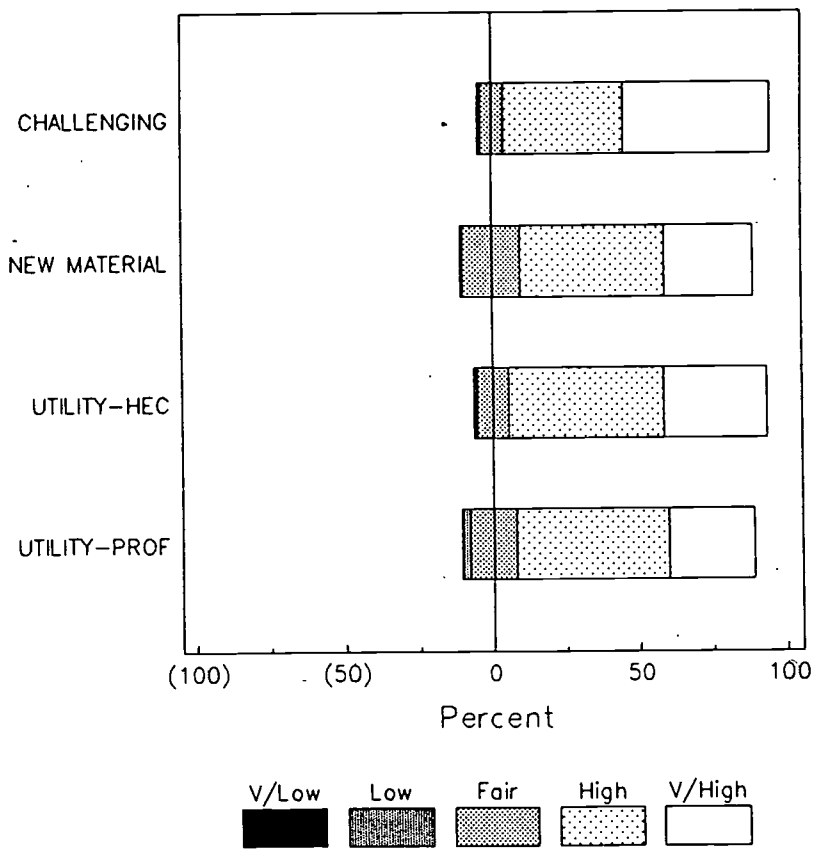
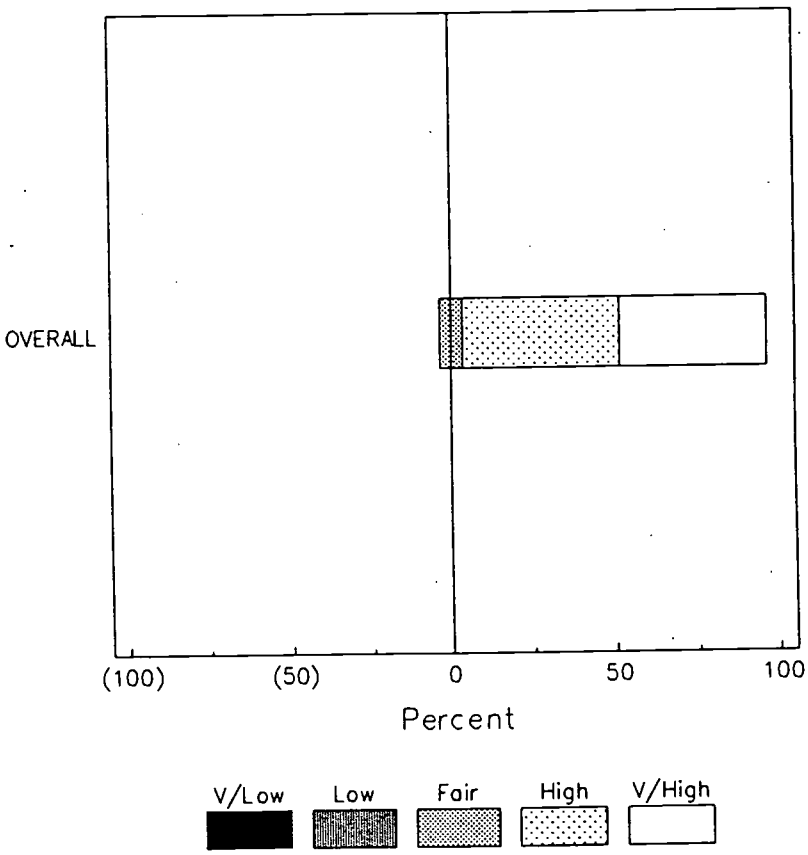


Fig. 7 Overall Evaluation
(n=628)



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A National DIssemination Project
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Wear	Levine
Agich	King
Weber	Kopelman
Jacobson	Gervais
Boisaubin	Rasinski
Iserson	Miedema
Blake	Zuckerman
Scofield	
ten Have	
McCartney	
Schwartz	
Foubert	
Wildes	
Lusky (Evaluator)	

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Blake ----------	Blake	Boisaubin	
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Moreno	Schwartz		
ten Have ----------		ten Have	
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Weber			
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* European citizen (Nijmegen, The Netherlands). Dr. ten Have was a student participant in the initial FIPSE program 1987-89), and serves as European Editor of HEC Forum.

EDUCATING HEALTHCARE ETHICS COMMITTEES: A NATIONAL DISSEMINATION PROJECT

FACULTY: BIOGRAPHICAL SKETCHES

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Judith Wilson Ross, M.A., is Associate, Center for Healthcare Ethics, St. Joseph Health System (440 S. Batavia St., Orange, CA 92668). She has taught courses in bioethics at the UCLA School of Law and in the College of Letters and Sciences. She is principal author of Handbook for Hospital Ethics Committees (1986) and co-author of Choosing Life or Death; she is also editor of Ethical Currents, Healthcare Ethics and Reform Literature Review, and co-editor of HEC Forum. In 1993 she published Health Care Ethics Committees: The Next Generation (1993) under the auspices of the American Hospital Association, Chicago, IL.

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BIOETHICS/HUMANITIES

George J. Agich, Ph.D., has been a Clinical Ethics Consultant for almost twenty years. He is presently Professor of Medical Humanities and Psychiatry, Director of the Values in Medicine Program at Southern Illinois University School of Medicine and Director of the Ethics Consultation Service at Memorial Medical Center, Springfield, Illinois. He helped found the Patient Rights Committee at McFarland Mental Health Center and the Human Values and Ethics Committee at Memorial Medical Center. In 1990, he was the primary presenter for "Bioethics Training for Community Physicians," a project funded by the Indiana Humanities Council that was awarded the 1990 Achievement Award by the IHC. He has lectured, conducted seminars and workshops, and published on a variety of topics in medical ethics including access to hospital ethics committees, brain death criteria, ethics consultation, withholding and withdrawing care decisions, and assessing competence to consent to treatment. He recently published Autonomy and Long-Term Care (Oxford University Press, New York, 1993).

Françoise E. Baylis, Ph.D., is Assistant Professor of Philosophy (Bioethics Education and Research) Dalhousie University, Halifax, Nova Scotia. From 1993-1996 she was Assistant Professor of Philosophy (Bioethics) at the University of Tennessee, Knoxville, Tennessee. From 1990-93 she served as full-time bioethicist at the Hospital for Sick Children, Toronto, Canada. Dr. Baylis obtained her Ph.D. in philosophy, specializing in bioethics, from the University of Western Ontario (1989). She continues her work as co-investigator on two ethics research projects: "The Development of an Ethics Curriculum for Pediatric Residents" and "Feminist Health Care Ethics," and serves on the Consent Panel of the National Council on Bioethics in Human Research (NCBHR). Among her research interests are ethics committee case reviews and consultations, pediatric ethics, and ethical issues in women's health.

David C. Blake Ph.D., J.D., received his Ph.D. from the Catholic University of America (1981) and his J.D. from Loyola Law School (1992). He is the Director of Bioethics Programs and Associate Professor of Philosophy at Loyola Marymount University, Los Angeles, California. He serves on the Bioethics Committees of St. Vincent Medical Center, Los Angeles, and St. John's Hospital and Health Center, Santa Monica, and is presently the chair of the Subcommittee on Institutional Ethics Committees of the Bioethics Committee of the Los Angeles County Bar Association. He is also a member of the Board of Directors, UniHealth America Foundation, UniHealth America Corporation. He has published several articles on healthcare ethics committees, anencephalic infants as organ donors, and the state interests in terminating medical treatment. Current research includes moral casuistry and the debate over medical futility.

Philip J. Foubert, Ph.D., is a bioethics consultant, working to strengthen ethics programs in healthcare institutions for clinical staff and lay members. He was a member of the Editorial Advisory Board of HEC Forum, and has edited Ethical Leadership in Health Care Management (1992), Bioethics and Health Care Reform Among the States (1992), and Theological Integrity in Health Care Ministry (1992). Before moving to the State of Washington, Foubert was a member of the medical humanities program at the University of Nebraska (Omaha). Prior to that time he was Director of Outreach Programs for the University of Virginia Center for Biomedical Ethics, where he taught in the College of Medicine and the Department of Religious Studies. He served as Coordinator of the Intensive Colloquies and Continuing Scholars Project, a national outreach program funded by the Pew Charitable Trusts, of five-day residential seminars in health care ethics for the "top 50" leaders in five key professional groups (hospital CEOs, religious leaders, state legislators, appellate judges, and journalists). Foubert received his B.A., from the Seattle University Honors Program in European History, and obtained his M.A. and Ph.D. degrees in Theological and Philosophical Ethics from the University of Notre Dame. He taught bioethics at the University of Dallas and at Catholic University of America.

Karen G. Gervais, Ph.D., is a philosopher and coordinator of the Minnesota Network for Institutional Ethics Committees of the Minnesota Hospital Association. She has been involved in bioethics education since 1975, when she developed an undergraduate program for pre-med and nursing students in a liberal arts setting. Her initial scholarship was in the area of death and dying: In 1987, she published Redefining Death with Yale University Press. Since 1989, she has been a Center Associate at the Center for Biomedical Ethics of the University of Minnesota. There she has participated in projects on neural grafting, fetal tissue transplantation, RU-486, genetic counselling,and living donation. She lectures extensively on the PSDA, living wills, termination of treatment decisions, and withdrawal of nutrition and hydration, and is engaged in developing educational programs for hospital and nursing home ethics committees throughout Minnesota. She develops ethics education programs for various medical specialties, and serves as consultant member of the St. Croix Valley Health Care Ethics Advisory Committee, which has developed an impressive community-based ethics committee model; she consults for the Veterans Administration Medical Center Ethics Committee. A part-time member of the St. Olaf College philosophy department, and the recipient of Carleton College's Winifred and Atherton Bean Visiting Chair of Professor of Science, Technology, and Society for 1993.

Loretta M.C. Kopelman, Ph.D., received her Ph.D. in Philosophy from the University of Rochester. She has taught philosophy at the University of Rochester, the University of Maryland, and is Professor and Chair of the Department of Medical Humanities at

East Carolina University School of Medicine, Greenville. She held various national offices, including Chair of the Faculty Association of Humanities Teachers in Medical Education, council member of the Society for Health and Human Values, and member of the Committee on Philosophy and Medicine of the American Philosophical Association. She is currently Chair of the Directors of Medical Humanities Programs of the Society for Health and Human Values. She is a member of the editorial board of The Journal of Medicine and Philosophy, and one of the editors of the second edition of The Encyclopedia of Bioethics. The books and articles she has published reflect her interest in the rights and welfare of children, retarded individuals, and research subjects; the ethics of research design; and the concepts of consent, competency, labeling, and compassion. She has co-edited: The Rights of Children and Retarded Persons (1978), Ethics and Mental Retardation (1984), and Children and Health Care: Moral and Social Issues (1989). Her articles have appeared in a number of professional journals.

James J. McCartney, Ph.D., is Associate Professor in the Department of Philosophy at Villanova University, Pennsylvania. He is also Ethics Consultant for two health systems, one based in St. Petersburg, Florida, and the other based in Brooklyn, New York. He serves on the ethics committees of the Graduate Hospital in Philadelphia and Our Lady of Lourdes Medical Center in Camden, New Jersey. He is also a member of the National Ethics Task Force of the Society for Critical Care Medicine. Previously, he was Director of the Bioethics Institute at St. Francis Hospital in Miami Beach, Florida, and served on several ethics committees of hospitals and nursing homes in south Florida. He was also an Associate Professor of Humanities at St. Thomas University in Miami as well as Adjunct Professor of Jurisprudence at its School of Law. From 1980 to 1985 he was Academic Vice President at St. Thomas University. He was a faculty member at the Georgetown University School of Medicine and a researcher at the Kennedy Institute of Ethics at Georgetown University. He holds a Ph.D. in philosophy from Georgetown University and has graduate degrees in cell biology (M.S., The Catholic University of America) and theology (M.A., Washington Theological Union). He has authored numerous articles and has co-edited an anthology dealing with the philosophy of medicine (Concepts of Health and Disease: Interdisciplinary Perspectives) with H. Tristram Engelhardt and Arthur Caplan. He was included as one of fifty-two Americans from all fields honored by Esquire magazine as part of the 1987 class of Esquire's National Register for his support and advocacy on behalf of persons with AIDS.

Jonathan D. Moreno, Ph.D., is Professor of Pediatrics and of Medicine and founding Director of the Division of Humanities in Medicine at the SUNY Health Science Center at Brooklyn. Dr.. Moreno has also held full-time academic appointments at George Washington University, the University of Texas at Austin, and Swarthmore College. He received the doctorate in philosophy from Washington University in St. Louis (1977). He has been Associate

for Social and Behavioral Studies at the Hastings Center, and was the first Philosopher-in-Residence at Children's National Medical Center in Washington, DC. He is a Fellow of the Kennedy Institute of Ethics at Georgetown University and an Adjunct Associate of The Hastings Center. During 1984-85 he was an Andrew W. Mellon Post-Doctoral Fellow in Association With the Aspen Institute for Humanistic Studies. Dr. Moreno is a member of the State of New York Organ Transplant Council and of the Committee on Bioethical Issues of the Association of the Bar of the City of New York, and has served on the President's Advisory Committee on Human Radiation Experiments (1994-95). He is also a consultant to the Ethics Committee of the American Association of Blood Banks. Dr. Moreno is a consulting editor for Medical Ethics for the Pediatrician, a member of the editorial boards of The Journal of Clinical Ethics and HEC Forum. He is co-author of Ethics in Clinical Practice (Little, Brown and Co., 1994) and author of Deciding Together: Bioethics and Moral Consensus (Oxford, 1995) and Arguing Euthanasia (Touchstone/Simon & Schuster, 1995)___

Henk A.M.J. ten Have, M.D., Ph.D. received his M.D. and Ph.D.(Philosophy) from Leiden University, the Netherlands. In 1983, he published his thesis on the influence of Jeremy Bentham on medical theory and practice. From 1982 to 1991 he worked in the University of Limburg, Maastricht, as Instructor, subsequently Professor of Philosophy and Catholic Religion, at the Faculties of Medicine and Health Sciences. He is Professor of Medical Ethics, and Chairman of the Department of Ethics, Philosophy and History of Medicine in the Faculty of Medical Sciences at the Catholic University of Nijmegen. He is directing the International Program in Bioethics Research and Education (organizing international research projects and an annual European Bioethics Seminar) as well as the research program "Health care practices and chronic disorders," and the EC awarded research project "Human Genome: Body, Identity and Property." He is founding member and secretary of the European Society for Philosophy of Medicine and Health Care. He serves as Editor-in-Chief of 'Ethiek en Recht in de Gezondheidszorg', a Dutch publication in health care ethics and law. He also serves as a member of the Editorial Advisory Board of Theoretical Medicine and Journal of Medicine and Philosophy. He is the European Editor of HEC Forum. Recently, he served as a member of the Dutch Government Committee on Choices in Health Care. He is a member of the Advisory Committee on Health Care Ethics and Law of the Dutch Health Council, and of the Committee on Investigative Medicine of the Council for Health Insurance. He serves on the Medical Ethics Committee of Nijmegen University Hospital.

Stephen Wear, Ph.D., received his Ph.D. degree in philosophy from the University of Texas at Austin in 1979, and has since been a member of the faculty at the State University of New York at Buffalo, with appointments to its departments of Medicine, Obstetrics-Gynecology, and Philosophy. He has also accepted

research and fellowship positions at the Institute for the Medical Humanities, University of Texas Medical Branch at Galveston, the Kennedy Institute of Ethics, Georgetown University, and The Hastings Center. He has lectured and published widely in the field of bioethics. His book, Informed Consent: Patient Autonomy and Physician Beneficence within Clinical Medicine, was published in 1993 (Kluwer Academic Publishers). He is a charter member of seven healthcare ethics committees in the western New York area; these include committees at three general hospitals, a tertiary care children's hospital, a Veterans Administration medical center, a county medical center, and a nursing home. In addition to serving on these committees, he also regularly engages in bedside ethics consultation in most of these institutions and serves as the Head, Ombudsman Consultation Team, Veterans Administration Medical Center-Buffalo. This team provides ethics consultation coverage to patients, families and staff.

Leonard Weber, Ph.D., received an M.A. from Marquette University and a Ph.D. in Religious Studies from McMaster University in Ontario, Canada. Since 1972, he has been on the faculty of Mercy College of Detroit, specializing in applied ethics. He has published two books and numerous articles. He presently directs the Ethics Institute of University of Detroit Mercy, a center for education, consultation, and research in health care ethics and in business ethics. He conducts ethics educational programs in a wide variety of settings and is a consultant to several hospital ethics committees. He is past President of the Medical Ethics Resource Network of Michigan.

Kevin Wm Wildes, S.J., Ph.D., is Assistant Professor, Department of Philosophy, as well as a Senior Research Scholar at the Kennedy Institute of Ethics and the Center for Clinical Bioethics, Georgetown University, Washington, D.C. He holds a advanced degrees from the Weston School of Theology, Cambridge, MA., and Fordham University in New York City, receiving the Ph.D. in Philosophy from Rice University in 1993; his dissertation focused on the foundations of bioethics. While serving as Managing Editor of The Journal of Medicine and Philosophy Professor Wildes was a member of the Center for Ethics, Medicine and Public Issues at Baylor College of Medicine, Houston, Texas. He has served as an ethics consultant to several of the Baylor teaching hospitals, and is a member of the Ethics Consultation Service at Georgetown University Hospital. He is presently Assistant Professor of Philosophy and a Research Scholar at the Kennedy Institute of Ethics, Georgetown University, Washington, D.C.

HEALTH LAW/BIOETHICS

Nancy M.P. King, J.D., is Assistant Professor of Social Medicine at the University of North Carolina School of Medicine. She attended St. John's College and the University of North Carolina School of Law, and worked in the General Counsel's Office of the Health Care Financing Administration in DHHS before joining the UNC Social Medicine faculty. She has also published on health law and medical ethics with scholars at Duke Law School and Georgetown's Kennedy Institute of Ethics. Professor King teaches legal, social, and ethical issues to medical students as part of a comprehensive social medicine curriculum at UNC. Her research interests center on the study of roles and responsibilities in health care decisions. She has worked extensively on issues related to informed consent, neonatal intensive care, the development and use of experimental technologies, and decisionmaking at the end of life. She is the author of Making Sense of Advance Directives, Georgetown University Press, 1996. She serves on a hospital Infant Care Review Committee and an industry Institutional Review Board, as well as on the editorial board of HEC Forum.

Dorothy C. Rasinski Gregory, M.D., J.D., is an attorney and a physician who has practiced internal medicine for almost 30 years. She established and was the first chairman of the Bioethics Committee at the Long Beach Veterans Administration Medical Center, was a founding member of the Orange County (CA) Bioethics Network, and is a current member of the VA's National Ethics Advisory Committee. A past president of the American College of Legal Medicine, Dr. Gregory is a member of the editorial boards of Journal of Clinical Ethics, Cambridge Quarterly of Healthcare Ethics, and Journal of Legal Medicine.

Robert L. Schwartz, J.D., is Professor of Law at the University of New Mexico School of Law (Albuquerque), and a Fellow of the Center for Health Law and Ethics. He has written extensively on issues in bioethics, health law, and on topics of concern to healthcare ethics committees. He is co-author of the comprehensive work, Health Law (West Publishing Co., St. Paul, MN, 1995). Professor Schwartz received his B.A. (with honors in philosophy) from Stanford University (1970), and his J.D. from Harvard Law School (1975). He was a post-doctoral fellow at The Hastings Center, and spent a year in England and India working on issues in comparative medical law. Recently, he spent a year teaching medical law at the University of Tasmania; he then received a Fulbright European Regional Research grant award to study issues in bioethics. Professor Schwartz has been a regular participant in judicial education programs on bioethics and health law, and served as the first chairman of the New Mexico Health Policy Commission, charged with developing a comprehensive health policy for New Mexico.

Giles R. Scofield, J.D., graduated with honors from Princeton University and received his law degree from New York University, where he received the Alan Teitler Award in Law and Medicine (1979). After working in private practice, he became Director of Legal Services at Concern for Dying (NYC), during which time he submitted amicus curiae briefs in a number of cases, including the Nancy Cruzan case. He has completed two research fellowships at the Cleveland Clinic and at Craig Hospital. He was Associate Professor and Director of the Health Law Program at Pace University School of Law (1993-96), and is presently Assistant Professor of Community Medicine and Health Care (Health Law) at the University of Connecticut School of Medicine (Health Center, Farmington). Dr. Scofield has lectured widely on a broad range of topics, and his articles have appeared in a number of professional journals. He has served on a number of HECs.

Connie Zuckerman, J.D., received her B.A., magna cum laude, from the University of Pennsylvania (1981), and her J.D. from New York University School of Law (1985); she was admitted to the Bar of the State of New York in 1986. Until late 1995 she served as Assistant Professor of Humanities in Medicine (Division of Humanities in Medicine) and Coordinator of Legal Studies at the State University of New York, Health Science Center - Brooklyn. She is presently employed by United Hospital Fund (350 5th Ave., 23rd floor, NYC, NY 10118). Dr. Zuckerman continues to serve as a guest lecturer for the SUNY College of Nursing and College of Health Related Professions. She is a member of several HECs, including the HECs at University Hospital of Brooklyn and the Visiting Nurse Association of Brooklyn. Dr. Zuckerman was an Assistant Professor in the Department of Epidemiology and Social Medicine at the Albert Einstein College of Medicine and a member of the ethics consultation service in the Division of Law and Ethics at Montefiore Medical Center, Bronx, New York. She is one of the founders (now Coordinator) of the Metropolitan New York Ethics Committee Network and Chair of the Association of the Bar of the City of New York's Committee on the Legal Problems of the Aging. Her numerous publications include "The Metropolitan New York Ethics Committee Network: Coming Together at a Time of Concern" (HEC Forum 5(2), 1993); she has published in The Hastings Center Report, The New York State Journal of Medicine, and Generations. She is co-author of Ethics in Clinical Practice, Little, Brown & Co., NY, 1994.

Eugene V. Boisaubin, M.D., received his B.A. from Washington University, and his M.D. from the University of Missouri. He completed his residency training in Internal Medicine at Baylor College of Medicine in Houston, Texas, and did graduate work in Medical Ethics at the Kennedy Center of Ethics, Georgetown University, Washington, D.C. He has been an Associate Professor in the Department of Medicine and the Center for Ethics, Medicine and Public Issues at the Baylor College of Medicine, and coordinator of the Ethics Consultation Service for The Methodist Hospital. He has authored over sixty articles and book chapters in the areas of General Internal Medicine, Medical Ethics, and the History of Medicine. He is presently Associate Professor of Medicine (John Sealy Hospital, Department of Medicine) and a member of the Institute for the Medical Humanities, University of Texas Medical Branch, Galveston, Texas. He is Director of the Ethics Consultation Service for the Department of Medicine.

H. Tristram Engelhardt, Jr., Ph.D., M.D., received his M.D. from Tulane University School of Medicine (1972) and his Ph.D. from the University of Texas at Austin (1969), where he completed his undergraduate work. For the academic year 1969-1970, he was a Fulbright Graduate Fellow at Bonn University, Germany, and in 1988-1989 he was a Fellow at the Institute for Advanced Study in Berlin Dr. Engelhardt is currently Professor in the Departments of Medicine, Community Medicine, and Ob/Gyn at the Baylor College of Medicine in Houston; in addition, he is Professor in the Department of Philosophy at Rice University, Adjunct Research Fellow at the Institute of Religion, and Member of the Center for Medical Ethics and Health Policy, Baylor College of Medicine, Houston, Texas. Prior to joining the Faculty at Baylor in 1983, Dr. Engelhardt was Rosemary Kennedy Professor of Philosophy of Medicine at Georgetown University, Washington, D.C. He is editor of the Journal of Medicine and Philosophy and co-editor of the Philosophy and Medicine book series. He has published over 200 articles and is the author of The Foundations of Bioethics (Oxford University Press, NY/Oxford, 1986; second edition, 1996) and Bioethics and Secular Humanism: The Search for a Common Morality (Trinity Press International/SCM Press, Philadelphia/ London, 1991). He has served on a number of HECs.

Kenneth V. Iserson, M.D., M.B.A., received his B.S. (1971) and M.D. (1975) from the University of Maryland, completed post-graduate training in surgery and a residency in emergency medicine at the Mayo Clinic and Cincinnati University Hospital, respectively; received his M.B.A. from the University of Phoenix (1986). He served in the U.S. Air Force and on the faculty of Texas A & M Medical School prior to joining the faculty of the University of Arizona College of Medicine in 1981 (Section of Emergency Medicine, 1501 N. Campbell Avenue, Tucson, AZ 85724). During 1990-1991, Dr. Iserson was a Senior Fellow in Bioethics at the Center for Clinical Medical Ethics of the University of Chicago's Pritzger School of Medicine. Dr. Iserson, as Professor

of Surgery, practices emergency medicine, is the Director of the Arizona Bioethics Program, and Chairman of the Bioethics Committee at University of Arizona Medical Center. He is the editor of Ethics in Emergency Medicine, 2nd ed. (Williams & Wilkins, Baltimore, MD, 1996), and other articles on topics in bioethics. He serves on the Steering Committee of the Maimonides Society (Tucson), on the editorial boards of several professional journals, and is the medical director of the volunteers of the Southern Arizona Rescue Association.

Jay A. Jacobson, M.D., has been a member of the University of Utah's and LDS Hospital's Division of Infectious Diseases since 1978. He is currently Professor of Internal Medicine and Chief of the Division of Medical Ethics in the Departments of Internal Medicine at both institutions. In 1988, Dr. Jacobson was selected for a special year-long educational program at the Center for Clinical Medical Ethics at the University of Chicago. The following year he returned to Utah where with colleagues from the College of Law, College of Humanities, and the School of Medicine he established a new Division of Medical Ethics. The Division is involved in clinical consultation, research, and teaching medical ethics to physicians in training, physicians in practice, and to interested individuals and organizations. Dr. Jacobson has served on the American Medical Association's Council on Ethical and Judicial Affairs, and he serves on two hospital ethics committees and the University of Utah's Institutional Review Board. He is a frequent contributor to HEC Forum.

June Levine, R.N., is Vice President Operations/Nursing at Huntington West Valley Hospital, Glendora, California, and holds the title of Assistant Professor, School of Nursing, University of Southern California, Los Angeles. Nurse Levine received her baccalaureate and master's degree in nursing from Ohio State University, and received certification in Nursing Administration from the American Nurses' Association. She has extensive experience as a Pediatric Clinical Nurse Specialist and as a Nursing Administrator in children's healthcare and general acute care. Nurse Levine has lectured frequently in the areas of nursing administration and ethical decisionmaking. She is the past chairperson of the American Association of Critical Care Nurses' Ethics Committee, past member of the California Nurses' Association Ethics Committee, and a member of the Los Angeles County Bar Association Ethics Committees. She has been a member of two Hospital Ethics Committees and has published two books in the area of ethics: Ethics at the Bedside (Lippincott, 1985), a source book for the Critical Care Nurse, and Creating an Ethical Environment (Williams & Wilkins, Baltimore, MD, 1991), a book focusing on ethics in nursing management.

Felicia A. Miedema, R.N., M.A., is a Clinical Nurse Ethicist at Lutheran General Hospital, Park Ridge, Illinois. She received her M.A. in Philosophy at Loyola University of Chicago (1994). In her position, Ms. Miedema provides consultation to nurses, physicians, patients and families who are struggling to resolve an ethical dilemma in patient care. She is a member of both the Bioethics Committee and the Institutional Review Board at Lutheran General. She conducts educational programs on ethical issues at Lutheran General Hospital and affiliated institutions, and is a frequent speaker on topics in healthcare ethics. Her publications include "A Practical Approach to Ethical Decisions," American Journal of Nursing, Dec. 1991; Withdrawal of Treatment from the Hopelessly Ill, Dimensions in Critical Care Nursing, 1993; and "The Nurse's Role on the Healthcare Ethics Committee (HEC Forum 5(2), 1993). Ms. Miedema served as Guest Editor of HEC Forum 7(4)95.

PROJECT EVALUATOR

Richard A. Lusky, Ph.D., received his Ph.D. in sociology from the University of Connecticut (1980). From 1985 to 1991 he was Director of the University's Gerontology Studies Unit located in the Department of Community Medicine and Health Care. In 1991, he was appointed Associate Professor in (and in 1993 Director of) the Center for Studies in Aging at the University of North Texas (Denton, TX 76203-3428). He served as Project Evaluator for "Educating Healthcare Ethics Committees, 1992-1996" as well as "Improving Hospital Ethics Committees, 1987-1989," both projects supported by grant awards from the Fund for the Improvement of Postsecondary Education (U.S. Department of Education, Washington, D.C.). Dr. Lusky's interest include ethical issues in long-term care as well as the social factors that bear on the health status of the elderly. He teaches gerontology, health care delivery, and research methods to graduate students and long-term care administrators in training.

EDUCATING HEALTHCARE ETHICS COMMITTEES (EHEC)

YEAR-1: 1-20 SITE VISITS - 1992-93

1.
Kathryn A. Koch, M.D., F.C.C.P. — 904-549-4075
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7th floor, Tower Bldg.
655 West 8th St.
Jacksonville, FL 32209

2.
Jackson "Joe" Yium, M.D., F.A.C.P. — 615-778-7583
Erlanger Medical Center -7808
975 E. 3rd St.
Chattanooga, TN 37403

3.
Shirley Heintz — 804-889-5234
Administrative Director -5080
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DePaul Medical Center
1510 Kinsely Lane
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4.
Michael Salvatore, M.D. — 717-321-2851
Williamsport Hospital
777 Rural Ave.
Williamsport, PA 17701

5.
Fr. A George Eber — 918-584-7300
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St. Anne Institute
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Tulsa, OK 74104

6.
Professor Richard Gelwick, Th.D. — 207-283-0171 x 125
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7.
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11.
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12.
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14.
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18.
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19. 317-929-5293
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Methodist Hospital of Indiana, Inc.
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Indianapolis, IN 46202

20.
Sr. Louise Lears, S.C. 719-636-8643
Penrose-St. Francis Health Care System
P.O. Box 7021
Colorado Springs, CO 80933

YEAR-2: 21-36 SITE VISITS - 1993-94

21.
Kim A. Carmichael, M.D., F.A.C.P. 314-768-3220
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Deaconess Medical Center-Central Campus
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22.
Karen G. Sloan 717-267-7795 (7981)
VP-Nursing
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23.
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Gulfport, MS 39502

24.
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Columbia, MO 65201

25.
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Sr. Rayne Sullivan, CSC
St. Agnes Medical Center
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26.
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27.
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30.
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707 South Mills St.
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31.
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Dean, College of Dentistry
Univ. Kentucky
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32.
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33.
Richard Corp — 209-385-7261
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34.
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35.
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YEAR-3 + 6 MONTHS EXTENSION: 37-60 SITE VISITS - 1994-96

37.
Amy Huber
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38.
Jan Heller, Ph.D.
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39.
Rafael A. Ruiz Quijano, M.D.
President, Comité Currículo
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40.
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42.
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43.
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Chair, Committee on Biomedical Ethics
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44.
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APPENDIX E

EDUCATING HEALTH CARE ETHICS COMMITTEES

EVALUATION PROCEDURES

Dear Ethics Committee Chairperson or Secretary:

As a condition of its support of this project, the Fund For Post-Secondary Education (FIPSE) requires that our work with Health Care Ethics Committees be evaluated in a consistent manner. The Agency has reviewed and approved the procedures outlined below and the enclosed evaluation form.

We realize that each Committee and/or site may have its own methods of evaluating educational programs and would be interested in receiving copies of your instruments and your evaluation results for this program. At the same time, it would be difficult to assess the quality and appropriateness of our different programs without comparable evaluation data from each site. Hopefully, our needs will not require too much additional effort on your part.

We are requesting that three types of information be forwarded to us in the enclosed priority mail envelope following your program: (1) Information on committee membership, (2) Information on program attendance, and (3) The committee members' assessment of the program using the enclosed form.

Committee Membership: Please send an up-to-date committee roster. If there are committee members who did not attend any sessions, it would be helpful, but not essential, to know: (a) their profession, (b) their highest degree and discipline, (c) the number of years that they have served on ethics committees, and (d) whether they have received formal ethics committee training in the past.

Attendance: Copies of the attendance sheets for each of the sessions listed in Section III of the enclosed evaluation form. For purposes of this evaluation, we are not concerned with the attendance at "optional sessions" which were not supported by FIPSE.

Assessment: Please schedule approximately twenty minutes following the last session for committee members to complete the enclosed evaluation forms. **If a sufficient number of forms have not been supplied, please make additional copies as needed.** Have the members place their completed forms in the business-size envelopes supplied, seal and sign the envelopes on the

outside, and return them to you. If members cannot complete the form in the time allotted, have them return the form to you as soon as possible.

When you have received sealed envelopes from all committee members attending one or more of the designated sessions, please enclose them in the self-addressed priority mail envelope along with the committee roster and attendance information, and mail the materials first class.

We have tried to make the evaluation process as straight forward as possible. Please be assured that the time which you and the committee members devote to evaluation of the program will be used to strengthen it in the future. Thank you for your cooperation.

EDUCATING HEALTHCARE ETHICS COMMITTEES

University of Florida Health Sciences Center, Jacksonville: April 7-9, 1993

Post-training Evaluation Form

DIRECTIONS: Please complete this confidential evaluation form, place it in the envelope supplied, and return it to your committee chairperson. Your chairperson will forward the sealed envelope to the project evaluator. Faculty will receive your input in an anonymous format.

I. CONTENT AND APPROACH

A. Please rate the training session on the following dimensions:

	Too Much	About Right	Too Little	NA
Breadth of material				
Depth of coverage				
Speed of presentation				
Time spent on lectures				
Time spent on discussion				
Amount of assigned reading				
Amount of preparation time				

B. Comments:_____

_____

II. ORGANIZATION

A. Please rate the training session on the following dimensions:

	Very High	High	Fair	Low	Very Low	NA
Clarity of Objectives						
Selection of Topics						
Sequencing of topics						
Value of lectures						
Value of discussions						
Value of handouts						
Appropriateness of readings						

B. Comments:_____

_____

C. Were any of the advance readings either particularly helpful or unnecessary?_____

_____

III. SUBJECT MATTER

A. Please rate the coverage of the following topics. Consider how useful the presented information will be in carrying out your ethics committee responsibilities:

	Very High	High	Fair	Low	Very Low	NA
Role of the Ethics Committee in Decision-Making						
Optimal Case Consultation Models						
Clinical Problems in Case Consultation						
The Issue of Medical Futility						
Legal Liability/Responsibility of Consultants						
Ethics Consultants as Expert Witnesses in Liability Trials						

B. Comments:_____

_____

IV. INSTRUCTION

A. Please rate the training session faculty on the following dimensions:

	Very High	High	Fair	Low	Very Low	NA
Overall clarity of instruction						
Scholarly level of instruction						
Instructor's interest/enthusiasm						
Readiness to provide assistance						
Responsiveness to questions/concerns						
Level of rapport with participants						

B. Comments:_____

_____

C. Do you have any suggestions which might help the session faculty present their material more effectively in the future?

Dr. Spicker: _____

_____

Dr. Scofield: _____

_____

Dr. Wear: _____

_____

V. OVERALL EVALUATION

A. Please rate the relevance of the training session on the following dimensions:

	Very High	High	Fair	Low	Very Low	NA
Intellectually challenging						
Exposure to new material						
Utility in meeting your ethics committee responsibilities						
Utility in meeting your other professional responsibilities						

B. Given your professional background, ethics committee experience, and health care environment, what was the most beneficial aspect of the training session? _____

_____

C. Given your professional background, ethics committee experience, and health care environment, what was the least beneficial aspect of the training session? _____

_____

D. In what ways might the seminar be improved? _____

_____

_____

E. Did the publicized description of the seminar accurately reflect its organization and content?

Yes ___ , No ___. Comments:_____

_____

F. How would you rate the seminar overall?

Very High	High	Fair	Low	Very Low

VI. PARTICIPANT DATA

To allow assessment of the benefits of the training sessions for participants with different backgrounds, please indicate:

Your profession : _____

The highest degree earned and discipline: _____

The number of years that you have served on an ethics committee: _____

Whether you have participated in formal ethics committee training in the past: Yes ___ , No ___.

APPENDIX F

EDUCATING HEALTH CARE ETHICS COMMITTEES

Post-training Evaluation Results

Sites 1-60: April 7, 1993 - March 12, 1996

I. CONTENT AND APPROACH

Please rate the training session on the following dimensions:

	Too Much	About Right	Too Little	Number Reporting
Breadth of material	4%	93%	3%	634
Depth of coverage	3%	91%	6%	636
Speed of presentation	5%	90%	5%	626
Time spent on lectures	9%	86%	5%	615
Time spent on discussion	3%	77%	20%	628
Amount of assigned reading	8%	75%	17%	355
Amount of preparation time	2%	83%	15%	367

II. ORGANIZATION

Please rate the training session on the following dimensions:

	Very High	High	Fair	Low	Very Low	Number Reporting
Clarity of Objectives	21%	59%	18%	2%		630
Selection of Topics	31%	61%	7%	1%		635
Sequencing of topics	21%	61%	17%	1%		620
Value of lectures	35%	55%	9%	1%		619
Value of discussions	38%	51%	9%	1%		635
Value of handouts	23%	52%	22%	3%		523
Appropriateness of readings	23%	60%	14%	2%	1%	385

III. SUBJECT MATTER

Please rate the coverage of the following topics. Consider how useful the presented information will be in carrying out your ethics committee responsibilities:

	Very High	High	Fair	Low	Very Low	Number of Ratings
Summary Ratings for 443 Sessions at 60 Sites	28%	51%	17%	3%	1%	4,025

IV. INSTRUCTION

Please rate the training session faculty on the following dimensions:

	Very High	High	Fair	Low	Very Low	Number Reporting
Overall clarity of instruction	39%	53%	7%	1%		629
Scholarly level of instruction	54%	41%	5%			629
Instructor's interest/enthusiasm	61%	36%	3%			635
Readiness to provide assistance	57%	38%	5%			626
Responsiveness to questions/concerns	57%	38%	5%			631
Level of rapport with participants	54%	40%	6%			626

OVERALL EVALUATION

A. Please rate the relevance of the training session on the following dimensions:

	Very High	High	Fair	Low	Very Low	Number Reporting
Intellectually challenging	50%	41%	8%	1%		636
Exposure to new material	30%	49%	20%	1%		631
Utility in meeting your ethics committee responsibilities	35%	53%	11%	1%		607
Utility in meeting your other professional responsibilities	29%	52%	16%	3%		613

E. Did the publicized description of the seminar accurately reflect its organization and content?

Yes = 93% **No = 7%** (Number Reporting = 525)

F. How would you rate the seminar overall?

Very High	High	Fair	Low	Very Low	Number Reporting
45%	48%	7%			628

VI. PARTICIPANT DATA

To allow assessment of the benefits of the training sessions for participants with different backgrounds, please indicate:

Your profession : (Number Reporting = 616)

Physicians = 23%, Nurses = 39%, Social Workers = 9%, Clergy = 8%, Administrators = 8%, Educators = 3%, Lawyers = 2%, Other = 7%

The highest degree earned and discipline: (Number Reporting = 610)

HS/Associates - 13%, Bachelors = 21%, Masters = 32%, MD/JD/Doctoral = 34%

The number of years that you have served on an ethics committee: (Number Reporting = 605)

1 or less = 39%, 2 = 18%, 3 = 12%, 4 = 8%, 5 = 7%, 6 = 4%, 7 = 3%
8 = 2%, 9 = 1%, 10 = 3%, 11 or more = 3%

Whether you have participated in formal ethics committee training in the past: (Number Reporting = 603)

Yes = 40% **No = 60%**

U.S. DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement (OERI)
Educational Resources Information Center (ERIC)

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